CHAPTER THREE

National Program Office

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THE ROLE OF the National Program Office (NPO) in the Program to Promote Long Term Care Insurance for the Elderly (currently known as the Partnership for Long Term Care) has involved numerous activities. In addition to acting as the liaison between RWJF and participating states on matters of grant management, the NPO has served as a principal source of technical assistance and direction on program research, planning, development, implementation, problem solving, and continuing quality improvement The NPO role carries the special challenge of being intimately involved with the states, but from a distance. The multistate perspective on the program has allowed the NPO to serve as a catalyst to the Partnerships' best practices and to actively participate in the learning process of the program. In this chapter we offer some insights from those experiences.

PROGRAM DEVELOPMENT

The mid-1980s' context within which RWJF began to explore ways to support innovations in long term care financing led Foundation staff to conclude that a state-based initiative on long term care insurance made sense. Private insurance for long term care had just begun to emerge as a credible product, but the market for this coverage was new (Meiners 1983) and underdeveloped (Meiners 1984). Consumers remained generally uninformed about the risks they faced (Meiners and Tave 1984), and insurers were just beginning to understand the prototype policies mat covered more than nursing home care (Meiners and Trapnell 1984). Because of their costly Medicaid responsibilities, states already were the main laboratories for testing long term care financing and delivery innovations and were responsible for regulating insurance. Most important, states were

beginning to see a role for themselves in achieving the potential of this new source of financing for reducing the long term pressure on their Medicaid programs.

Several states responded to the long term care financing problem by proposing initiatives to help make private long term care insurance appealing and affordable to the general public. In response to these initiatives, RWJF gave planning grants to eight states, California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin, as part of the Foundation's Program to Promote Long Term Care Insurance for the Elderly (Somers and Merrill 1991). The purpose of the program was to provide states that had demonstrated a commitment to reforming long term care financing with resources to investigate the potential role of a public-private insurance partnership in long term care financing.

Although differing in detail and context (Meiners and McKay *1989),* each state set out to achieve a. basic set of goals outlined by RWJF staff in establishing the program (Merrill and Somers 1989):

- avoid impoverishment among elderly families by guaranteeing asset and income protection;
- ensure access to quality long term care services;
- cover a full range of home-and community-based services;
- develop a case management infrastructure in which the gatekeeper bears some financial risk to prevent excessive or inappropriate utilization; and
- ensure equity and affordability in the long term care insurance program for lower income citizens.

To make these goals operational, the states participating in the RWJF program focused on strategies to encourage the development and purchase of private insurance options by those who could afford them, on subsidizing those who could only partially afford them, and on ensuring coordination with programs that were fully publicly funded. Reorientation rather than expansion of current public responsibilities was central to program planning. Strategies suggested to the states included:

- educational campaigns to enhance public awareness;
- regulatory review to encourage market flexibility while promoting consumer protection;
- support for improved data development and sharing to minimize uncertainty; and
- coordination of public cost and care management mechanisms (e.g., preadmission screening, utilization review, case management,

benefit coverage, and rate regulation) with those of the private market (Meiners 1988).

State consideration of such interventions was prompted by concern that the market for private insurance needed help to achieve its potential. The available products were neither widely appealing nor affordable. However, it was recognized that increasing product quality also increases cost, which reduces affordable coverage. State planners also needed the program to be at least budget neutral (no increase in the cost of doing business), if not to save Medicaid money. Solving the cost-quality dilemma in this context was at the heart of the program planning process (Meiners 1993).

MAKING THE CASE FOR COST-EFFECTIVENESS

Whereas the states started with a variety of ideas on how to encourage the use of long term care insurance to help their citizens avoid impoverishment, the approach for those that implemented their program was the same: buy a state-qualified insurance policy and get special asset protection (McCall, Knidonan, and Bauer 1991). The difficulty of product design in terms of the trade-off between quality and cost was handled by assuring the purchaser that something other than lifetime coverage would still provide protection from impoverishment. Non-Partnership policyholders risk having to spend virtually all savings before qualifying for Medicaid if the benefits are exhausted. In contrast, when a Partnership policy is exhausted, the policyholder is then eligible for coverage under Medicaid without having to deplete savings.

Budget neutrality is the program's basic goal because it sets the stage for other advantages, including better coordination of public and private sector roles in long term care financing and delivery systems, better insurance products and market oversight, and the potential for Medicaid savings. Savings could result because:

- consumers would have a more appealing alternative to transferring assets as a way to avoid Medicaid's claim on these resources;
- care management assistance and preferred provider arrangements under private insurance have the potential to control unnecessary utilization and costs, which could help individuals stretch resources; and
- the additional income earned on "protected assets" would be applied toward the cost of care.

Policymakers recognized that the exact amount of resources people may have at the time long term care is needed is not easy to predict.

Under these circumstances, individuals use their best judgment, and some may purchase policies that provide protection in excess of their current Medicaid-countable assets in anticipation of such income as inheritance, life insurance benefits, or reverse mortgage annuities. In addition, certain individuals might choose to insure some portion of the value of their home (which is only protected by Medicaid under certain circumstances), knowing they might decide to sell it and move to more manageable housing.

Because the extent of behavioral changes can be determined only through a demonstration, the magnitude of savings can only be estimated. To help make the case for this approach, the NPO undertook some actuarial modeling to assess the cost-effectiveness potential for both states and consumers. To assess the impact of the asset protection incentive on public budgets, the program relied primarily on the Brookings/ICF Long Term Care Financing Model[1] as the basis for testing assumptions. Although the model is national rather than state specific, it has been employed by a variety of users, including DHHS, to assess the impact of public and private changes to our long term care financing system. As such it was viewed as a credible basis for providing empirical backing for our claims of budget neutrality.

The results helped show that savings were possible. Medicaid was found to save an increasing amount as the program matured, reaching a projected 11 percent reduction in spending by the period 2016-2020. This represents about a 7 percentage point drop in Medicaid's share of the total long term care bill by the last years of the simulation period. The simulation also suggested that the share of out-of pocket expenses could drop by about 9 percentage points, with insurance paying about 16 percent of the total long term care bill (NPO 1991). Later simulations done as part of the 1993 Clinton Health Reform planning effort estimated either modest costs or savings, depending on the underlying assumptions, leading that group to accept the approach as budget neutral.

Other simulation work done by the NPO shows that the benefits of insurance under the Partnership are more attractive to consumers than the benefits of insurance alone, even with more coverage and higher premiums. Without the Partnership, only lifetime coverage can give complete assurance that a person will not be impoverished by long term care expenses. With the Partnership, this same assurance can be obtained from more limited, less expensive coverage (Goss and Meiners 1993). This simulation work also suggested that the asset protection incentive could nearly double the potential market, with the greatest addition coming from those with moderate asset levels.

Program Implementation

Four of the original eight states (California in 1994, Connecticut in 1992, Indiana and New York in 1993) implemented a public-private partnership designed to help balance the competing pressures between product value and price by expanding Medicaid eligibility in exchange for purchasing a state-certified Partnership insurance policy. Insurers participating in the Partnerships were required to meet program certification standards designed to ensure that participating long term care policies were of high quality. Among the standards required were inflation protection and minimum benefit amounts to help ensure the policy would protect the purchaser's assets when care was needed. Participating insurers were also required to provide the state with information on purchasers of certified products and on utilization of benefits.

The details of the programs, however, differed from state to state. The most interesting difference is between New York and the other states. New York bases its asset protection incentive on time rather than the dollar amount of coverage purchased (Holubinka 1992). Partnership policies are required to pay three years of nursing home care, six years of home care, or some combination of the two (with two days of home care equaling one day of nursing home care), after which all remaining assets are protected. A priority of the New York approach is to offer a viable alternative to asset transfers (Nussbaum 1992).

By protecting all assets once the insurance is exhausted, the New York approach serves as a strong counter to asset transfers, which involve a loss of control of one's savings. Transfers of assets are relatively common in New York (Burwell 1993). Any strategy that encourages individuals to take financial responsibility for their own care rather than divest their assets could yield savings to the state.

The underlying logic of the "total assets" model is that the period of insurance is equal to or exceeds the average time during which a person would be paying for long term care. At the time, the average nursing home length of stay was 2.5 years. Because the costs of long term care are so high in New York, this length of stay translates into the real threat of middle class persons' exhausting their assets if long term care were needed. Before the Partnership was implemented, transferring assets to protect them was viewed as "rational fiscal thinking." Whenever a state can get long term care insurance rather than Medicaid to pay for care, it can save money.

The total assets approach was modified to the dollar-for-dollar model as a way to offer both an alternative to divestiture and to give persons of different means the option of choosing the amount of protection most in line with

their ability to pay. Thus, an individual with $50,000 in assets might buy $50,000 in insurance protection while another individual with $150,000 in assets might buy $150,000 in insurance protection. Insurance payments for long term care services are considered equivalent to the spending of assets to establish Medicaid eligibility. Once on Medicaid, individuals would be able to keep control of assets up to the amount that insurance paid. Connecticut was the first to adopt this approach, followed by Indiana and California (Mahoney 1992).

The opportunity to protect extra resources applies only to assets and not to income. Income must be applied to the cost of care once insurance runs out People expecting to have high income when they exhaust their insurance may not qualify for Medicaid asset protection because their income will cover the entire bill.

However, this tends to be more of an issue at the high end of the market, so it was not viewed as a major program concern. The states recognized, that neither model was appropriate for everyone: Some people are too dose to Medicaid eligibility to consider private insurance and others can self-insure.

Although it might have been simpler if all states used the same approach, both models have unique strengths that have served the program well The total assets model provides the maximum incentive and is arguably easier to understand because of its one-size-fits-all approach. It also fits better with existing products in that it requires at least three years of nursing home coverage, which had been the industry standard throughout much of early market development As such, the average commission per sale tends to be higher. Therefore, insurers and agents are often viewed as preferring the total assets model to the dollar-for-dollar approach. They see it as a reasonable compromise sale for those who cannot afford lifetime coverage. This type of coverage is fast becoming the new industry standard sale, but not everyone can afford it.

The special strength of the dollar-for-dollar model is that it makes purchases of insurance protection in the range of one to three years more meaningful and more affordable to those in the middle to modest income group, those who are most at risk for spending down their resources and requiring Medicaid. Without the special asset protection incentive offered by the Partnership, the market for long term care insurance is less likely to extend to this group. In fact, around the time the Partnership was beginning. NAIC seriously discussed whether to require at least two years of coverage for long term care policies. The Partnership has helped make a case for the value of short term comprehensive benefits that include inflation protection.

The initial plan to implement the Partnership program was to follow the example of the Social Health Maintenance Organizations (SHMOs) and the Program for All-Inclusive Care for the Elderly (PACE) by get-

ting congressional support for the waivers needed for state programs. However, some key opposition in Congress to linking Medicaid and long term care insurance emerged. Fortunately, the back-up strategy of using an amendment to a state's Medicaid plan, first identified and pursued by Connecticut, proved to be permissible under Medicaid's rules (Mahoney and Wetle 1992).

Currently several states are hoping to get the best of both asset protection incentive strategies by using a hybrid approach that grants dollar-for-dollar asset protection up to a certain amount and provides total asset protection thereafter. Illinois, one of the states most interested in replicating the Partnership program, originally chose the dollar-for-dollar model but revised the program to provide total asset protection for those who buy $220,000 or more of protection. Indiana has new legislation that will revise its Partnership to provide total asset protection for those who buy a policy covering at least $147,000. These amounts are targeted to cover about four years of nursing home care at current rates and increase by 5 percent compounded each year.

KEY INGREDIENTS IN SEEKING SUPPORT AND RECOGNITION

The process of gaining support and neutralizing opposition has proved to be an ongoing challenge with unexpected twists. The program set out to be a win-win-win solution for consumers, insurers, and government (Meiners and Goss 1994).

A key message for consumers is that those in Partnership states can obtain assistance with catastrophic long term care expenses without becoming impoverished. Assets protected under the Partnership can mean the difference between autonomy and dependence if a policyholder exhausts his insurance and still needs assistance. Policyholders also need not be concerned about state and federal government efforts to stop Medicaid estate planning. Participants can control their funds instead of worrying about how someone else might be handling their money if they had transferred assets to relatives or friends to avoid spending savings on long term care.

Consumers also benefit because Partnership policies are subject to oversight beyond that conducted for non-Partnership policies and carry a stamp of approval from the states indicating they have met special certification requirements. In addition, all participating insurers are required to provide the state with extensive data for program monitoring.

For insurers, the message is that they can benefit from the increased attention brought by the Partnership to the issue of long term care financing and the important role that insurance can play. As part of the program, educational campaigns are increasing public awareness about what long

term care is, the risks of needing long term care, and limited financing options. The public information campaigns are multifaceted and directed at persons for whom long term care insurance may be especially beneficial.

Working with the state also enhances the credibility of insurance as a way to protect against the risks of long term care. The market for long term care insurance ran be expanded to include the majority of potential purchasers who have viewed this protection as too expensive. Under special arrangements with the state, participating insurance companies can assure policyholders they no longer have to be impoverished to qualify for Medicaid even if they could only afford three years of coverage or less.

For states, the message is that the Partnership provides a fiscally conservative form of premium subsidy. Only those who buy a policy and use the benefits receive the special protection. Program-related expenditures occur well after program initiation, and savings would be accruing to cover future costs. In contrast, traditional premium subsidies (including tax breaks) entail public expenditures at the time of purchase for all purchasers.

The Partnerships bring the states into a closer working relationship with insurers, providing both the means and the incentive to monitor insurer performance. The states can pursue regulations to minimize Medicaid estate planning with less controversy, knowing people are being given a reasonable alternative. This is mutually beneficial to the state and to insurers, who have had the difficult task of competing against the asset transfer option.

However, getting the right message out to the right audience has not always gone smoothly. For example, with the exception of New York, the states did not initially recognize how important agents were to the process of consumer education. Insurance agents are often the key to policy sales, most of which are made on an individual basis. New York, with its emphasis on combating asset transfers early on, focused on the agents as well as on professional financial planners and elder law attorneys as key targets of the Partnership message.

California, with the advantage of a later start date, did make a concerted educational effort with agents. However, its initial product design sought to facilitate consumer comparison of policies and premiums by prescribing a uniform set of benefits and coverages mat did not include some secondary benefits popular with agents and included in the non-Partnership products. When design or price differs significantly from non-Partnership policies, agents tend not to sell Partnership policies. Sales of California Partnership policies have skyrocketed (up 800 percent over the corresponding period in the prior year) since California redesigned its policies in 1998 so that benefits, coverage options, and premiums are essentially the same as non-Partnership policies (except for built-in inflation protection).

The task of achieving acceptance of Partnership policies in the marketplace has been complicated by the fact that the states defined their roles as educating consumers on long term care risks and options rather than promoting long term care insurance. General consumer education on long term care did not always translate well in support of the Partnership as a state-sponsored response to the long term care financing problem. Insurers and agents wanted and expected marketing. It was a tricky balance in emphasis.

As the Partnership unfolded, each of the states became more adept at getting their message out to key participants. They used grant funds to hire professional marketing firms to help with agent training, for outreach to state and local media, and for publication of newsletters. Closer relationships were forged with the state Health Insurance Counseling and Assistance Programs (HICAPs) to help soothe concerns about advocating for or against insurance. Although melding consumer education on the risks of long term care with the marketing of insurance remains difficult, progress is being made. State efforts have been bolstered by Congress and the national media, which have increasingly focused on long term care insurance as an important financing option for consumers to consider.

BARRIERS TO PROGRAM IMPLEMENTATION

Win-win-win situations rarely can be claimed on all details of a deal. How the parties see the total program and the context within which they see that program matter as well (Meiners and McKay 1990; Mahoney and Meiners 1994). In the early stages of program development, arguments against the Partnership were raised primarily by social insurance advocates who viewed the program as an incremental step that would erode support for more ambitious long term care reform.

The idea of the Partnership was launched at a time when relatively little was heard of universal health insurance or even lesser social insurance strategies. It seemed the Partnership was an approach that could help states deal with long term care in a budget-neutral way that could easily be supported. Arguments were made mat the Partnership program could help mitigate concerns about means testing and that programs for the poor are inadequate because they lack broad-based political support. By linking the Partnership incentive to Medicaid, the constituency for the means-tested program could be enhanced rather than eroded. The belief that this argument could sway naysayers turned out to be naive thinking, bad timing, or both.

As long term care insurance began to emerge as a viable financing instrument, the extension of the private market was viewed by some key

players as more of an obstacle than an aid to long term care reform.
For advocacy groups such as AARP and Families USA, the means-tested Medicaid program was viewed as part of the problem crying for a social insurance solution. The linking of long term care insurance with Medicaid as away to address financing problems of long term care was philosophically unacceptable, if not damaging to the cause of social insurance.

Shortly after the Partnership was implemented, this opposition became legislation with the enactment of OBRA in 1993. This act grandfathered the existence of the four RWJF state programs but put restrictions on further replication.

States obtaining a state plan amendment after May 14,1993 face additional requirements. While they are allowed to proceed with Partnership programs, they must recover assets from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the Partnership is in effect only while the insured is alive. After the policyholder dies, states must recover from the estate what Medicaid spent, including protected assets.

At the time the Partnership programs were implemented, interest in the Partnership had grown well beyond the four states funded by The Robert Wood Johnson Foundation. As many as 12 states passed enabling legislation to create programs modeled on the Partnership. OBRA 1993 has had the effect of stifling this interest It effectively took away the opportunity for other states to consider the Partnership strategy, which has served the four RWJF states well in preparing their citizens to consider the risk of long term care in their retirement planning.

It is important to note that advocacy group opposition to the Partnership approach was far from unanimous. As the states worked to gain a consensus on key issues, local consumer representatives from groups such as AARP often ended up supporting the Partnership despite opposition from their national offices. Local advocates liked the consciousness raising that went with the process of gaining acceptance of the enhanced standards. Every RWJF Partnership was enacted as a result of unanimous votes in the state legislature.

THE CRITICAL ROLE OF INSURERS AND AGENTS

The Partnership program would not have been developed without the significant support of the insurance industry. Initially 22 insurers sought and received approval of a Partnership product in one or more states. These insurers are significant market participants, accounting for 45 to 75 percent of policies sold in the participating states and about 74 percent of all policies sold nationwide (McCall, Bauer, and Korb 1996).

The program represents a major change in the traditional relationship of state government and insurers. Contact has usually occurred only through the Department of Insurance, which mostly related to product approval and company solvency issues. The Partnership evolved a new layer of responsibility. Fortunately, when the program began, key insurers felt strongly mat the market for long term care insurance could benefit from the visibility and credibility brought about by working closely with states. Insurers and states agreed on the importance of private responsibility in paying, for long term care and the need to avoid dependence on Medicaid.

In all Partnership states, at least some insurers have actively participated in planning and implementing product design, consumer education, and marketing. In-kind contributions toward printing and distribution of materials are common in participating states, and several have collected contributions toward general education and marketing activities. In most states the participation of insurers has been through regular meetings, although in New York the arrangement is more formal: An evolution board, comprised of equal voting members from the state and participating insurers, oversees the Partnership.

As the Partnership was implemented, insurers and agents voiced dissatisfaction with certain aspects of program design. Requirements have deviated from some standard approaches used to market this coverage and have required attention beyond that for non-Partnership products.

Even before recent discussion of block grant programs and cutbacks in federal funding, the future form of Medicaid was uncertain. Concerns about the link to Medicaid resonated with the Partnership insurers and agents, as well as with program developers. The model cannot be easily generalized because many state Medicaid programs do not offer comprehensive home and community benefits or a system of care management that supports the continuity of care desired in such a partnership. States that have not developed strong programs for the poor will have trouble justifying such asset protection models.

For some insurers and agents this uncertainty surrounding Medicaid reinforces the marketing practice of selling against Medicaid. Many insurance agents try to avoid Medicaid and emphasize lifetime coverage. Yet getting lifetime coverage on a limited budget often leads to dropping inflation protection. Instead, the Partnership strongly encourages shorter comprehensive coverage that is inflation protected because it gives lifetime asset protection at a cost that fits a wide array of household budgets.

Another problem in convincing insurance agents to understand and buy into the Partnership message is that the primary audience for Partnership insurance differs from the market that agents customarily work with.

Selling to the high end of the income and asset spectrum is easier than targeting sales to those most in need of Partnership products. The problem is compounded by the fact mat agent commissions are directly related to the size of the premiums they sell.

The lack of portability of the asset protection feature has also been cited as a barrier to sales. Since only a few states have Partnership programs and the details of each state's Medicaid program are variable, reciprocity agreements that allow asset protection away from the home state have not been established at the time of this writing. While this has no effect on the value of the private insurance coverage itself, it is a concern for those who may move out of state and who depend on the asset protection feature as the primary motivation for choosing a Partnership policy.

More recently, some participating insurers have cited state by state differences in Partnership program details as being costly and time consuming. Nearly all insurers participating in the Partnership have maintained their regular product offerings. The Partnership policy development, approval process, and data reporting are an additional set of responsibilities they have committed to carry out.

CONTRIBUTIONS TO DATA

One of the best examples of the partnership characteristic that emerged in this program is the uniform data system developed through the cooperative efforts of the states, the insurers, the NPO, and the program evaluator. Because of the interest and controversy surrounding the Partnership concept, participating states knew it was essential to require information from insurers by which they could monitor both the program and the state's potential liability.

During the implementation process, insurers realized that each of the four Partnership programs intended to promulgate a unique set of requirements. HIAA arranged a meeting where it strongly encouraged making reporting requirements uniform, which would encourage more insurers to participate. Shortly afterward, state program staff agreed that following through on this suggestion was important to the success of the Partnership. This set in motion the creation of the uniform data set (UDS).

The states decided to capture detailed information at the individual insured level so that characteristics of persons purchasing insurance and utilizing benefits could be tracked. Person-level data would serve to assure that information about asset protection would be available to insured persons and to the state if and when Medicaid contributed to a persons long term care expenses. This database has been used in the evaluation work of Laguna Research Associates as reported on in chapter 8.

CONTRIBUTIONS TO QUALITY

One of the most significant contributions the four state Partnerships feel they have made is in product quality. As will be elaborated in chapter *4,* the states learned from and built on each other's experiences. Local program goals, a state's particular Medicaid program and social services delivery system, the makeup and relative power of the parties at the negotiating table, and the national policy environment all affected the way Partnership standards unfolded in each state.

The Partnership states have been active in developing product innovations and quality improvements. Perhaps the most important contribution is the provision of a way for consumers to buy high quality long term care insurance without sacrificing inflation protection and other quality-enhancing features available on the market This in turn has allowed the states to aggressively stimulate and support efforts to improve product quality. Some noteworthy areas of accomplishment include:

- development of objective measures of the "insured event”;
- removal of artificial restrictions on the use of community-based care or nursing home services;
- improvement of care management approaches to better meet individual needs;
- stabilization of premiums around common plan definitions and procedures; and
- prevention of unintentional lapses of coverage for those with cognitive impairments.

CONCLUSION

The Partnership for Long Term Care is providing a rich source of experiences for understanding the role insurance can play in helping people prepare for the catastrophic risks associated with long term care. This overview has discussed both the positive and negative aspects of the program development and implementation experience. Much has been learned from both.

The Partnership is now at the stage where revisions and refinements are being made to increase market impact. State budgets are becoming the predominant source of financial support as RWJF grant funding is nearing the end. In three of the four states, the Partnership has already been made a permanent part of the Medicaid program with line item budget support. California has just extended its program for five years.

New York's "evolution board" is actively considering program updates.

The other three Partnership programs have recently redesigned their policies to make them more compatible with the current market while preserving quality coverage for persons of modest means. The redesign efforts have resulted in dramatic increases in sale in all three states.

In all states the introduction of tax-qualified plans brought about by the Kassebaum-Kennedy legislation has prompted renewed interest in the long term care insurance market. An early indication of the effect of tax-favored status of long term care insurance is anticipated within the next few years as the baby boom generation enters its mid-5os, prime time for preretirement planning. However, it seems likely that more man just this incremental step **is** needed and that there will be renewed interest in finding ways to reach the broader market The lessons learned in the Partnership program will be valuable to mat renewed interest.

NOTE

I. The Brookings/ICF Long Term Care Financing Model simulates the number of elderly individuals using long term care services and the cost of these services by source of funds (Le., public and private) through 2020. It was developed jointly by Lewin/ICF and the Brookings Institution in 1986 and revised using updated data in 1988 and 1989. The model first simulates pension and retirement income and then simulates disability, utilization of long term care services, and utilization of sources of financing. Data sources include the 1979 Current Population Survey, Census Bureau data. Economic Assumptions from the 1988 Social Security Trustee's Report Alternative II-B), the 1982-84 National Long Term Care Survey, the 1985 National Nursing Home Survey, the 1984 Survey of Income and Program Participation, and Medicare and Medicaid data.

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